



VIRGINIA MANAGED CARE OPERATIONAL REPORT

SFY2018 Annual Report



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Letter from the Director

Dear Stakeholders,

My first year as Director has been marked by major changes to Medicaid and managed care in the Commonwealth. The state fiscal year 2018 has included the completion of the new Commonwealth Coordinated Care (CCC) Plus program, for long term services and supports, as well as the successful procurement of the Medallion 4.0 program. This report was created as a compilation of both CMS managed care regulations, as well as JLARC recommendations, to increase oversight of our managed care programs here in Virginia. This work laid the foundation for Medicaid Expansion, which provides access to health coverage for nearly 400,000 low-income Virginians beginning January 2019. Many exciting changes, and challenges, are in store for Virginia Medicaid in the coming years, and everyone here at the Department is looking forward to rising to meet them.



Sincerely,

Jennifer S. Lee, M.D.

Director, Virginia Department of Medical Assistance Services

Introduction

Pursuant to federal regulations found in 42 CFR § 438.66(e), the Department of Medical Assistance Services, hereafter referred to as the Department or DMAS, has compiled this annual report on managed care operations for Virginia for SFY2018.

The regulation requires the annual report to include the following:

- Financial performance of each Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), and Prepaid Ambulatory Health Plan (PAHP), including Medical Loss Ratio (MLR) experience.
- Encounter data reporting by each MCO, PIHP, or PAHP.
- Enrollment and service area expansions (if applicable) of each MCO, PIHP, PAHP, and Primary Care Case Management (PCCM) entity.
- Modifications to, and implementation of, MCO, PIHP, or PAHP benefits covered under the contract with the State.
- Grievance, appeals, and State fair hearings for the managed care program
- Availability and accessibility of covered services within the MCO, PIHP, or PAHP contracts, including network adequacy standards.
- Evaluation of MCP, PIHP, or PAHP performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.
- Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.
- Activities and performance of the beneficiary support system.
- Any other factors in the delivery of LTSS not otherwise addressed above.

In addition to creating this report, the Federal regulations require that the report must be:

- Posted on the Web site, required under § 438.10(c)(3).
- Provided to the Medical Care Advisory Committee, required under § 431.12.
- Provided to the stakeholder consultation group specified in § 438.70, to the extent that the managed care program includes Long-Term Services and Supports (LTSS).

Overview of Medicaid & Managed Care in Virginia

Medicaid plays a critical role in the lives of over a million Virginians, financing health care for the poor and medically vulnerable. The impact of Medicaid extends far beyond the financing of traditional health coverage to include comprehensive services such as behavioral health and long-term services and supports (LTSS) and addiction recovery and treatment services. Medicaid coverage is primarily available to Virginians who meet specific income thresholds and other eligibility criteria. Children, pregnant women, parents, older adults, and individuals with disabilities make up a significant portion of Virginians enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) is the agency responsible for administering the Medicaid program in Virginia.

Summary of Changes and Innovations

The 2018 state fiscal year saw a number of major changes and innovations to the Medicaid program, particularly with managed care. At the beginning of July 2017, there were two managed care programs: Medallion 3.0 and Commonwealth Coordinated Care (CCC). By the end of June 2018, the Department had not only stood up our second statewide managed care program, Commonwealth Coordinated Care (CCC) Plus, it had also closed out CCC. In addition, the Department:

- Oversaw the transition of eligible members from Medallion 3.0 to CCC Plus, including the aged, blind, and disabled (ABD) and the Health and Acute Care Program (HAP) population
- Successfully procured the new Medallion 4.0 program, which started rolling out in August 2018
- Implemented the Addiction and Recovery Treatment Services (ARTS) benefit that provides treatment for those with substance abuse disorders across the state
- Mandated MCO participation in the Virginia Emergency Department Care Coordination program, providing a single, statewide technology solution that connects all hospital emergency departments in the state to facilitate real-time communication and collaboration, beginning with the CCC Plus program and the future Medallion 4.0 program
- Implemented the Prescription Drug Common Core Formulary, requiring the MCOs to include, at a minimum, all of the preferred drugs on the DMAS Preferred Drug List (PDL), which is available at <https://www.virginiamedicaidpharmacyservices.com/>.
- New Encounters Processing System (EPS), developed by the DMAS Information Management (IM) division, that was fully implemented with the CCC Plus Program and partially implemented in Medallion 3.0 (full implementation in Medallion 4.0)
- Successfully implemented a behavioral health redesign with the CCC Plus Program and the future Medallion 4.0 program
- Ensured alignment of both CCC Plus and Medallion 3.0 & 4.0 contracts (where applicable), including rolling in community mental health services, early intervention services, consumer directed personal care, and third party liability (TPL) members (CCC Plus and Medallion 4.0)
- Beginning of DMAS preparations for Medicaid Expansion, effective in January of 2019

Managed Care Programs in Virginia

Managed care is a service delivery model where contracted private health plans coordinate care to ensure member needs are met and control costs through full-risk, capitated contracts. Virginia's Medicaid managed care programs in SFY2018 were Medallion 3.0 and CCC Plus.

As of April 2017, 87% of Medicaid enrollees received their benefits through a Managed Care Organization (MCO) and 13% of enrollees participated in full benefit Medicaid through the Fee for Service (FFS) program. Virginia has been increasing its use of the MCO programs because of the value it provides to enrollees and the Commonwealth. Managed care can provide budgetary predictability. Managed care also can include benefits such as call center with 24/7 access, care coordination, additional technology, and enhanced provider networks.

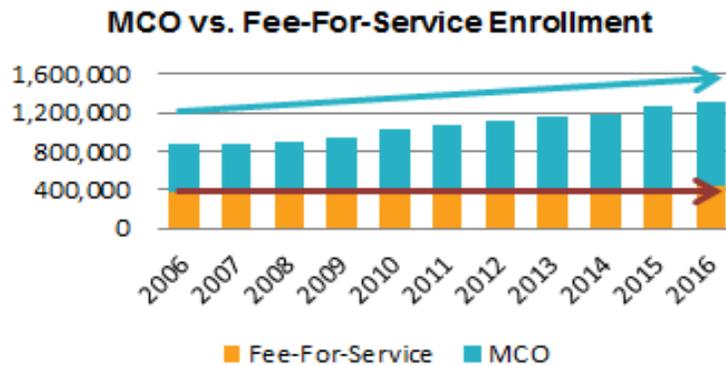


Figure 1: Trend of DMAS Enrollees in Managed Care vs. Fee for Service

Medallion 3.0

Medallion 3.0 is a statewide mandatory Medicaid program that operates under a CMS §1915(b) waiver and utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. The original Medallion program was Virginia’s first managed care program and dates back to 1996. Over the past 20 years, the Medallion program has provided acute and primary care services for enrolled members including: pregnant women, low-income families with children (LIFC), those receiving temporary assistance for needy families (TANF), and aged, blind and disabled (ABD) individuals, and children. The Medallion program has an established commitment to continuous improvement, which is a major factor in the re-procurement for the new Medallion 4.0 program, which started in August 2018.

During SFY2018, the ABD adults and children transitioned from Medallion 3.0 to CCC Plus, along with other eligible populations. Medallion 3.0’s focus shifted with its changing population to an increased focus on maternal and child health, including foster care children and adoption assistance members. This program covers approximately 60% of the Medicaid and FAMIS enrollees, or about 730,000 members as of June 2018. Eligible populations include:

- Children under age 21;
- Foster Care and Adoption Assistance Children under age 26;
- Pregnant women including two months post-delivery;
- Parents and Caretaker Relatives

The Medallion 3.0 MCOs are Aetna Better Health of Virginia, Anthem HealthKeepers Plus, INTotal Health, Kaiser Permanente, Optima Family Care, and Virginia Premier. Unlike CCC Plus, the Medallion 3.0 MCOs operate on a regional or locality-specific basis, with only one plan operating statewide in SFY2018. Additionally, Medallion 3.0 has seven (7) regions, compared to the six (6) regions used by CCC Plus. Beginning with Medallion 4.0, the Medallion program will align with the six-region model used by CCC Plus.

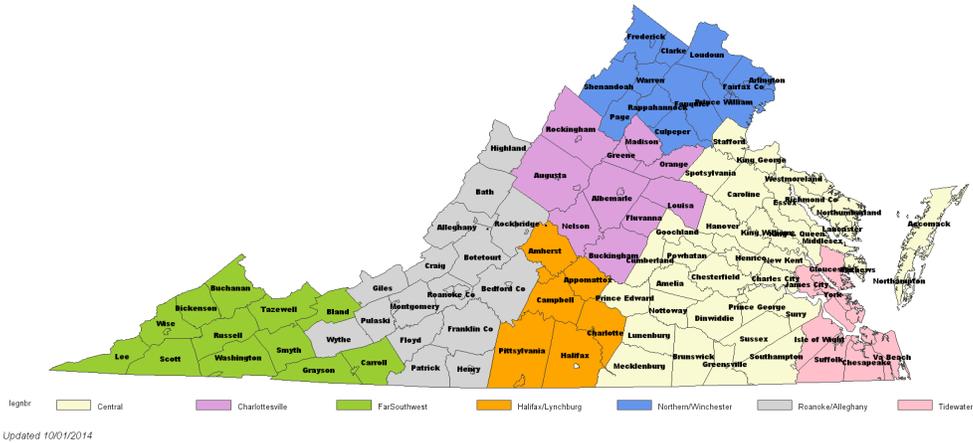


Figure 2: Medallion 3.0 Regional Map

Commonwealth Coordinated Care (CCC) Plus

The CCC Plus program is the Department’s mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from four (4) of the Department’s five (5) home and community-based services (HCBS) 1915(c) waivers. CCC Plus rolled in services that were previously carved out of mandatory managed care, including community mental health services, early intervention services, consumer directed personal care, and third party liability (TPL) members (Medallion 4.0 will carve in these services as well). The program also had members that transitioned from Medallion 3.0 and CCC into CCC Plus, including the ABD adults and children populations.

All CCC Plus members receive care coordination through a person-centered program design, and is an integrated delivery model that includes medical and behavioral health services with LTSS. This program covers approximately 18% of the Medicaid and FAMIS enrollees, or about 212,000 lives as of June 2018.

CCC Plus began in the Tidewater region on August 1, 2017 and rolled out to each of the other five regions by December 2017, so that the program was operational statewide. On January 1, 2018, remaining eligible populations moved from Medallion 3.0 to CCC Plus.



Figure 3: CCC Plus Regional Map

Participation is mandatory for these eligible populations, which include:

- Individuals ages 65 and older;
- Adults and children with disabilities;
- Individuals eligible for Medicare and Medicaid (Dual Eligible)
- Non-Dual Eligible receiving LTSS (facility and community based);

- Members in the Developmental Disabilities waiver (for non-waiver services only)

It is important to note that the populations currently not eligible for CCC Plus include, but are not limited to, the following (for a full list of excluded populations, please see the CCC Plus MCO contract found at <http://www.dmas.virginia.gov/#/cccplusinformation>):

- Psychiatric Residential Treatment Centers (RTC) facility programs
- Individuals enrolled in the Commonwealth's Medallion and Title XXI CHIP programs (FAMIS, FAMIS MOMS)
- Individuals enrolled in a PACE program
- Dual eligible individuals without full Medicaid benefits
- Individuals with temporary coverage or who are in limited coverage groups

The CCC Plus MCOs are Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health Community Care, UnitedHealthcare, and Virginia Premier Elite Plus.

Managed Care Benefits

Each managed care program offers a suite of benefits to its enrollees. These benefits are available to all managed care members of the program for which they qualify, regardless of the MCO they select. The following sections outline the benefits provided under Medallion 3.0 and CCC Plus during SFY2018 (7/1/2017 to 6/30/2018).

Summary of Benefits

Below is a list of the basic health services offered to managed care members, regardless of MCO. Members also access MCO-specific details of their benefits through the Member Handbooks provided by each MCO and by program. Basic health benefits include:

- Addiction and recovery treatment services (ARTS).
- Behavioral (mental) health services, counseling and 24/7 crisis line.
- Care coordination services (where applicable).
- Diagnostic services including x-ray, lab and imaging.
- Durable medical equipment (DME) and supplies.
- Emergency and urgent care.
- Family planning services.
- Health care for children including checkups, immunizations (shots) and screenings.
- Hospital and home health services.
- Interpreter and translation services.
- Maternity and high-risk pregnancy care.
- Medical transportation services.
- No co-pays* except patient pay towards long-term services and supports and any Medicare Part D drug co-pays. *CCC Plus only
- Physical, occupational and speech therapies and audiology services.
- Prescription drugs and over-the-counter medications (when prescribed by doctors).
- Preventive and regular medical care.
- Routine eye exams and glasses for children and routine eye exams for adults.
- Team approach (interdisciplinary care).
- 24 / 7 nurse advice line.
- Women's health services.

Details about each program's current benefits can be found on the respective Maximus websites.

- CCC Plus: <https://cccplusva.com/>
- Medallion: <https://www.viriniamanagedcare.com/home>

Enhanced Services/Added Benefits

While each MCO provides the core benefits that all managed care members have access to within CCC Plus or Medallion 3.0, an MCO can offer enhanced services, beyond the core benefits, to its members. These enhanced services, also called added benefits, are another way to offer choice to the managed care members to find the MCO that meets their needs.

Summary of Medallion 3.0 Enhanced Services

Each year, Medallion 3.0 updates a comparison chart for the members, which is available publicly on the DMAS website as well as the website of the enrollment broker, Maximus. Additional details of the role of Maximus are outlined in the "Beneficiary Support System (Maximus)" section of the report. This comparison chart is one of several tools offered to the members to allow the members to make an informed choice when selecting their MCO. Some examples of enhanced services include:

- Adult dental and vision (partial benefit only)
- Smartphones and online tools (apps, texts, etc.)
- Wellness programs such as fitness centers and smoking cessation
- Non-medical transportation (grocery stores, food banks, farmers markets, etc.)

Summary of CCC Plus Enhanced Services

In its first year of operation, CCC Plus adopted Medallion 3.0's comparison chart format as a way to provide at-a-glance information for members to understand the enhanced services offered by the CCC Plus MCOs. As with Medallion 3.0, the comparison guide is published publically on the DMAS website as well as with the enrollment broker, Maximus. Some examples of enhanced services include:

- Adult dental and vision (partial benefit only)
- Personal care attendant support
- Assistive technology devices
- Home delivered meals

Managed Care Enrollment

This section provides a brief overview of the enrollment in each of the managed care programs. While reviewing the enrollment data, it is important to keep in mind that while CCC Plus MCOs cover members across the whole state, Medallion 3.0 does not. Certain MCOs only participate in specific regions or localities, which affects member enrollment numbers.

Both managed care programs have algorithms to determine enrollment based on a variety of factors, including case history, MCO location participation, or random assignment. Ultimately, however, each member has the power to change their MCO, either for a period after their initial enrollment and again during the annual open enrollment period, in order to find the MCO that best meets the member's needs.

CCC Plus Enrollment

Below is a breakdown trend of total CCC Plus enrollment in SFY2018. While reviewing this information, it is important to remember that CCC Plus was implemented in August 2018 and certain populations were moved from Medallion 3.0 to CCC Plus in January 2018, including the aged, blind, and disabled population.

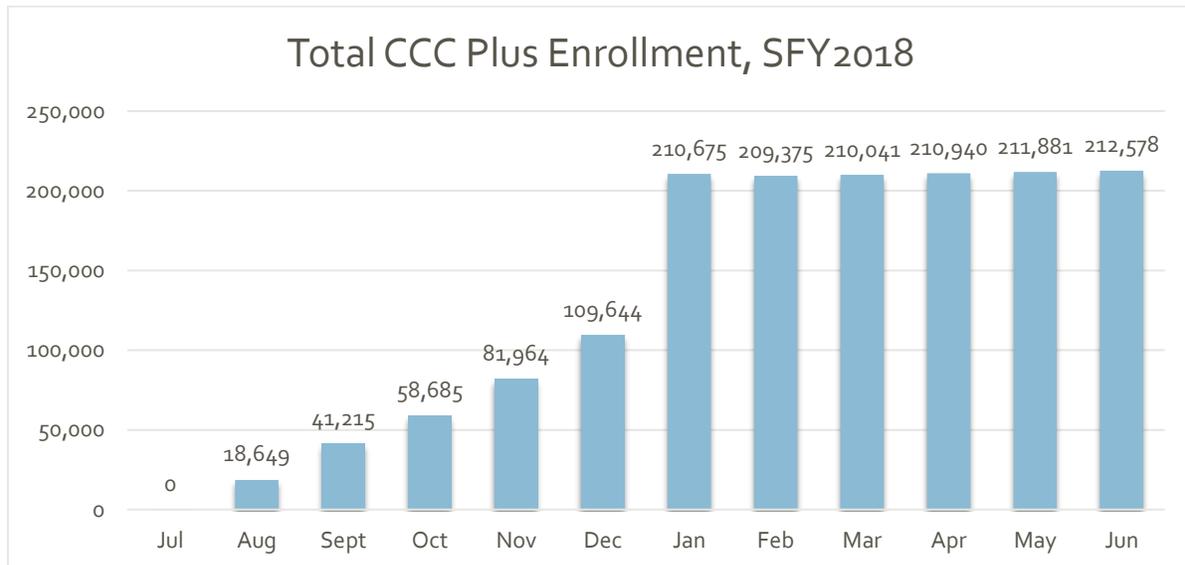


Figure 4: Total CCC Plus Member Enrollment SFY2018 as of 6/1/2018; Source: VAMMIS and CCC Plus Enrollment Reports

In this graph, the total population of CCC Plus for SFY2018 is broken down by MCO. This data reflects the population as of June 7, 2018.

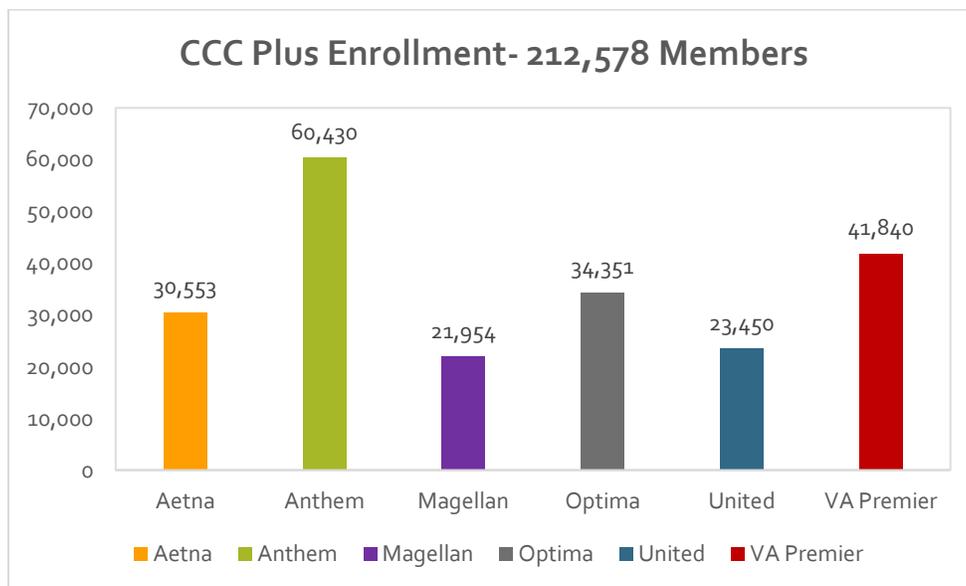


Figure 5: Total CCC Plus Enrollment as of 6/7/2018; Source: CCC Plus Enrollment Report, June 2018

Medallion 3.0 Enrollment

Below is a breakdown trend of total Medallion 3.0 enrollment in SFY2018. While reviewing this information, it is important to remember that certain populations were moved from Medallion 3.0 to CCC Plus in January 2018, causing the decrease in the Medallion 3.0 population seen below.

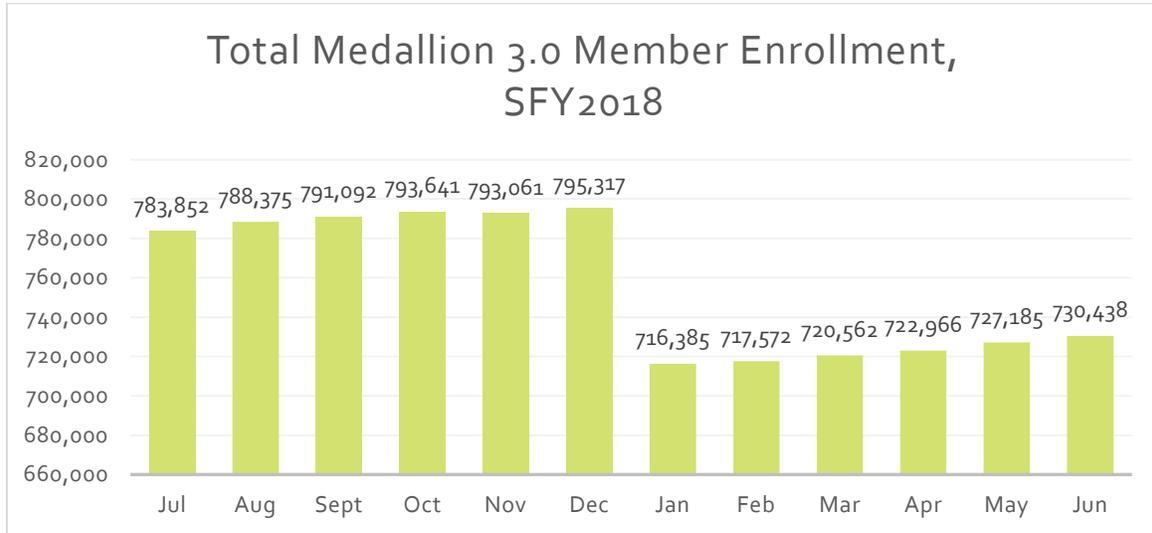


Figure 6: Total Medallion 3.0 Member Enrollment SFY2018 as of 6/1/2018; Source: VAMMIS

In this graph, the total population of Medallion 3.0 for SFY2018 is broken down by MCO. This data reflects the population as of June 1, 2018. Enrollment reflects where the MCOs offer services, and Anthem HealthKeepers was the only statewide Medallion 3.0 MCO.

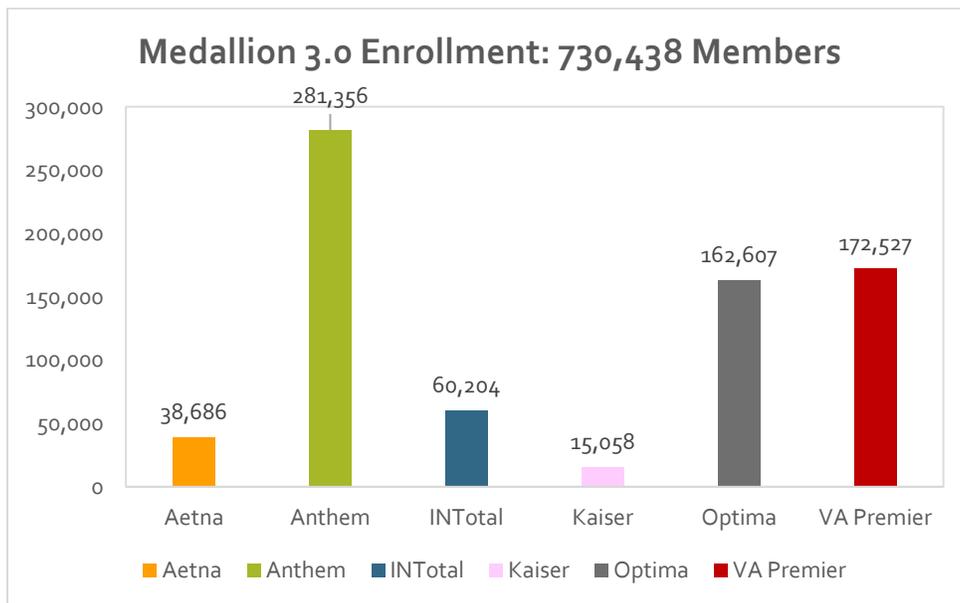


Figure 7: Total Medallion 3.0 Enrollment as of 6/1/2018; Source: VAMMIS

Beneficiary Support System (Maximus)

DMAS contracts with the company Maximus as the beneficiary support system and enrollment broker for both Medallion 3.0 and CCC Plus. Maximus operates enrollment services via a helpline and website, with the aim to educate and assist Medicaid members and the public with managed care topics, including enrollment, plan selection, assessments, and provider participation questions. Maximus staff are trained to assist members with making an informed decision regarding their MCO plan for their program. Maximus reports activities to DMAS on a regular basis on operations for CCC Plus and Medallion 3.0.

Medallion 3.0 Annual Summary

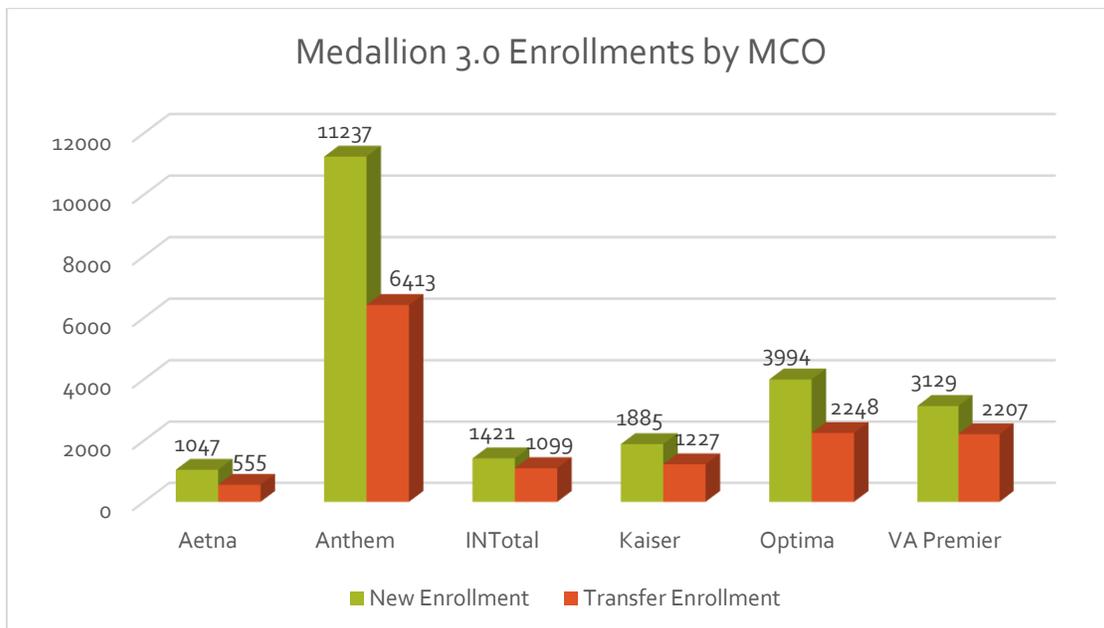
Below is a summary of different Maximus activities in SFY2018 for Medallion 3.0.

Maximus Helpline Annual Summary SFY2018: Medallion 3.0 Program				
Total Calls Answered	Average Calls Handled per Month	Highest Call Volume (Month)	Lowest Call Volume (Month)	Overall Abandonment Rate
101,111	8,792	11,216 (Jan)	7,009 (May)	4.16%

General inquiries made up 27.57% of all Medallion 3.0 calls in this reporting period, enrollment calls made up 22.59%, MCO calls made up 16.98%, and verifying eligibility made up 13.58%. The remaining 19.28% of calls cover a number of topics, including but not limited to address changes, language transfers, and good cause requests.

Maximus' Helpline processed a total of 36,462 enrollments, 22,713 new enrollments and 13,749 90-day transfer enrollments in the reporting period for Medallion 3.0.

Below is a summary of the Medallion 3.0 enrollments by MCO, including new and transfer enrollments for SFY2018.



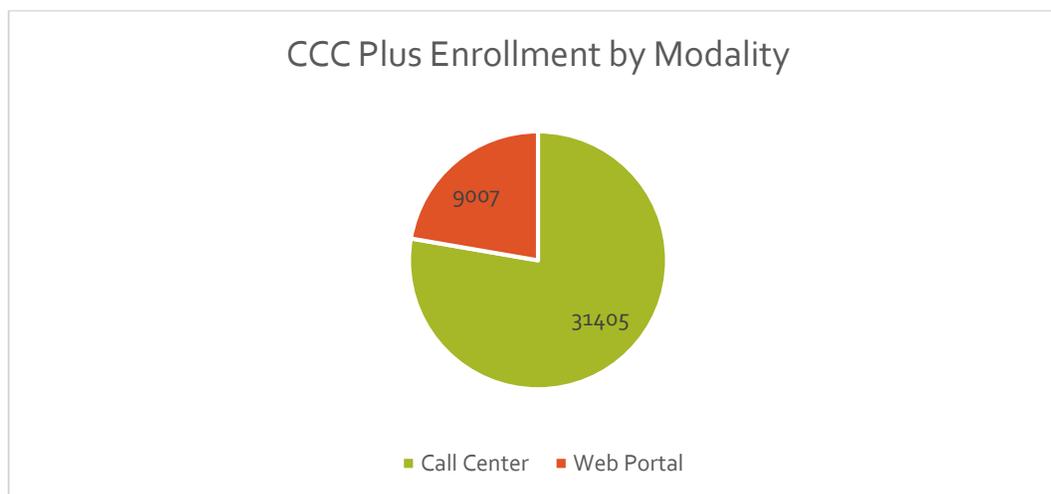
CCC Plus Annual Summary

Below is a summary of different Maximus activities in SFY2018 for CCC Plus.

Maximus Annual Summary SFY2018: CCC Plus Program				
Total Calls Answered	Average Calls Handled per Month	Highest Call Volume (Month)	Lowest Call Volume (Month)	Overall Abandonment Rate
106,347	9,355	16,654 (Jan)	4,030 (Jun)	5.27%

General inquiries made up 40.32% of all CCC Plus calls in this reporting period, enrollment calls made up 22.96%, MCO calls made up 12.73%, and verifying eligibility made up 12.66%. The remaining 11.33% of calls cover a number of topics, including but not limited to address changes, language transfers, and good cause requests.

Maximus processed 40,412 total CCC Plus enrollments. Of those, 31,405 enrollments were processed via the call center and 9,007 enrollments processed via the self-service web portal.



Quality Performance

DMAS prioritizes quality improvement in all managed care programs. As such, the Department requires each MCO in each managed care program to complete federal and state mandated quality improvement activities. These include:

- Participation in a quarterly collaborative
- Reporting of Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data
- Participation in performance improvement projects
- Measure validation activities
- Participation in either a performance incentive award program (Medallion 3.0) or quality withhold program (CCC Plus)

DMAS also published the agency-wide quality strategy for 2017-2019 where it outlines the goals and initiatives for the managed care programs with a focus on quality improvement for all Medicaid

members, regardless of program. The report is available publicly on the DMAS website (<http://www.dmas.virginia.gov>).

NCQA Accreditation

Below is the NCQA Accreditation status for the Medallion 3.0 MCOs for SFY2018. The MCOs must be accredited with NCQA for both managed care programs. As CCC Plus is a new program, the MCOs have a timeline and benchmarks they must meet while they are in the process of becoming NCQA accredited (if they are not already accredited).

HEALTH PLAN	NCQA ACCREDITATION	LEVEL
 AETNA BETTER HEALTH SM OF VIRGINIA		ACCREDITED
 Anthem HealthKeepers Plus Offered by HealthKeepers, Inc.		COMMENDABLE
 An Inova Health Plan		ACCREDITED
 KAISER PERMANENTE SM		EXCELLENT
 Optima Family Care A Service of Sentara		COMMENDABLE
 Virginia Premier Health Plan, Inc.		ACCREDITED

HEDIS[®] Performance

For SFY2018, DMAS deemed improvement in 29 Medicaid HEDIS[®] performance measures as a priority. The MCOs are expected to assure annual improvement in these measures if they are performing below the 50th percentile nationally, sustain performance in or above the 50th percentile and set goals to perform in the 75th percentile. During HEDIS[®] year 2018 MCOs aligned with the National Committee for Quality Assurance (NCQA) requirements, by not rotating any HEDIS[®] measures. Thirteen (13) priority HEDIS[®] measures improved from HEDIS[®] year 2017 to 2018:

HEDIS® Year 2018 Measures with Rate Increase
Adolescent Well-Care Visits
Cervical Cancer Screening
Childhood Immunization Status- Combo 3
Children and Adolescents' Access To PCP (12-19 Years)
Children and Adolescents' Access To PCP (7-11 Months)
Comprehensive Diabetes Care – Blood Pressure Control (<140/90)
Comprehensive Diabetes Care – Eye Exams
Comprehensive Diabetes Care - HbA1c Control (<8%)
Comprehensive Diabetes Care – Medical Attention for Nephropathy
Medication Management for People With Asthma: Medication Compliance 75% (Total)
Prenatal and Postpartum Care- Postpartum Care
Prenatal and Postpartum Care- Timeliness of Prenatal Care
Well-Child Visits in the first 15 Months of Life (6 or more visits)

Of the 29 deemed priority measures, an additional six measures had either significant methodology changes or insufficient data to allow trending across data collection years. HEDIS® also collects data for a calendar year, not for the state fiscal year and so HEDIS® year 2018 represents MCO submitted data from calendar year 2017.

This section focuses on HEDIS® measures for the Medallion 3.0 program, as Medallion 3.0's data collection for the quality measures allowed for reporting in this period (calendar year 2017). The CCC Plus MCOs are in the process of NCQA accreditation and establishing a data collection year as this is the first year of the CCC Plus program and as such, do not have HEDIS® data to report at this time. CCC Plus will report its first year of HEDIS® measures in HEDIS® year 2019.

Consumer Decision Support Tool

DMAS works with its External Quality Review Organization (EQRO), HSAG, to produce annually a Consumer Decision Support Tool, using Virginia Medicaid MCOs' performance measure data as its basis. The tool was developed to report MCO performance information to the public and to assist consumers in making informed decisions about their health care. The tool provides a three-level rating scale with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that clearly emphasizes meaningful differences between MCOs to assist consumers when selecting a health plan. This tool is available on both DMAS' website and Maximus's enrollment web site.

VIRGINIA MEDICAID MANAGED CARE QUALITY CONSUMER DECISION SUPPORT TOOL 2017-2018

Comparing Virginia Medicaid Managed Care Organizations

Choosing a managed care organization (MCO) that works best for you and your family is important. This tool is designed to help eligible members choose a Medicaid MCO. This tool shows how well the different MCOs provide care and services in various performance areas. The ratings for each area summarize how the MCO performs on a number of related standards.

Key

- Above Virginia Medicaid MCO Average ★ ★ ★
- Virginia Medicaid MCO Average ★ ★ ★
- Below Virginia Medicaid MCO Average ★

MCO	Accreditation Level	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna*	Accredited	★ ★	★ ★	★ ★	★ ★	★
Anthem	Commendable	★ ★	★ ★	★ ★	★	★ ★ ★
INTotal	Accredited	★ ★	★	★	★	★
Kaiser Permanente	Excellent	—	★ ★	★ ★	★ ★	★ ★ ★
Optima	Commendable	★ ★	★ ★	★	★ ★	★
VA Premier	Accredited	★ ★	★ ★ ★	★ ★	★ ★	★ ★

*Formerly CoventryCares
— Indicates the MCO did not have enough data to receive a rating.

What is Measured in Each Performance Area?

Doctors' Communication

- Doctors explain things well to members
- Doctors involve members in decisions about their care

Getting Care

- Members get the care they need, when they need it

Keeping Kids Healthy

- Children get regular checkups and important shots that help protect them against serious illness

Living With Illness

- Members with asthma, diabetes, high blood pressure, and depression get the care they need by getting tests, checkups, and the right medicine

Taking Care of Women

- Women get tests for breast and cervical cancer to help find these diseases early
- Moms get care before and after their baby is born to help keep mom and baby healthy

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Choosing a Medicaid Managed Care Organization

Your health care is important, and choosing the MCO that best meets your needs is also important. Here are some questions to ask yourself before you pick an MCO:

- How well did each MCO perform in each performance area in this tool?
- Which MCO has all or most of the doctors, providers, and hospitals that my family and I visit?
- Which MCO has doctors with office hours and locations that are convenient for my family and me?
- Which MCO offers extra services that I want to use?

You may have other questions or concerns that are important to you. You can contact the MCOs using the information below. They can tell you which doctors are available to you and what extra services they offer. You can also call the Medicaid Managed Care HelpLine at 1-800-643-2273. HelpLine staff can answer your questions and help you decide which MCO is best for you and your family.



MCO	Contact Information	Available in the Following Regions
Aetna Better Health of Virginia (Aetna)*	1-800-279-1878 www.aetnabetterhealth.com/virginia	Central Virginia, Far Southwest Virginia, Halifax, Lower Southwest Virginia
Anthem HealthKeepers Plus (Anthem)	1-800-901-0020 www.anthem.com/vamedicaid	Available in all regions.
INTotal Health (INTotal)	1-855-323-5588 www.intotalhealth.org	Far Southwest Virginia, Lower Southwest Virginia, Northern Virginia, Upper Southwest Virginia
Kaiser Permanente	1-855-249-5025 thrive.kaiserpermanente.org/medicaid/virginia	Northern Virginia
Optima Family Care (Optima)	1-800-881-2166 www.optimahealth.com/plans/family-care	Available in all regions.
Virginia Premier Health Plan (VA Premier)	1-800-727-7536 www.virginiapremier.com	Available in all regions.

*Formerly CoventryCares

Information as of December 2017



For More Information:
Visit the Virginia Department of Medical Assistance Services online at: www.dmas.virginia.gov and Virginia's Medicaid Managed Care online at: www.virginiamedicaid.com.

About This Tool
The 2017 Virginia MCO Consumer Decision Support Tool utilizes results from HEDIS and CAHPS. Calendar year 2016 data were used to derive 2017 reporting year rates. This report was compiled by Health Services Advisory Group, Inc. (HSAG) in collaboration with the Department of Medical Assistance Services (DMAS).

About the Accreditation Levels

Accreditation levels as of December 2017 are based on compliance with the National Committee for Quality Assurance's (NCQA's) rigorous requirements and the MCOs performance on Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures. The highest level of accreditation an MCO can receive is Excellent, followed by Commendable, and then Accredited. For more information regarding accreditation levels as of December 2017, visit: <http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels>.

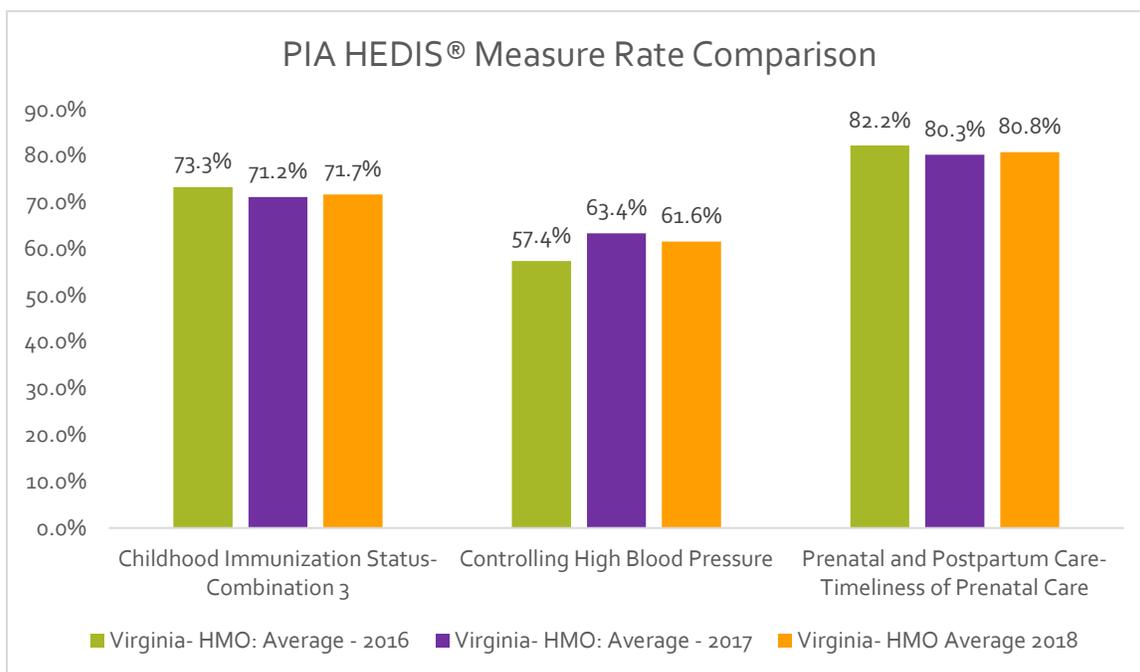
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Medallion 3.0 Performance Incentive Award (PIA)

In alignment with goals and objectives of managed care quality improvement in Virginia, the PIA program was created to improve health outcomes for members in the FAMIS and Medallion 3.0 populations as well as to promote and incentivize MCOs' high performance on six measures representing two measurement domains. For the first domain, administrative measures, DMAS selected the following administrative measures, assessments of Foster Care Population, MCO Claims Processing, Monthly Reporting Timeliness and Accuracy, and the following HEDIS measures:

1. Child Immunization Status—Combination 3
2. Controlling High Blood Pressure
3. Prenatal and Postpartum Care—Timeliness of Prenatal Care



HSAG calculated and finalized PIA results for all six MCOs in Virginia in December 2018. The Program Year 3 PIA results indicated that two MCOs were assessed for awards and four MCOs were assessed for penalties for their performance in state fiscal year 2018. All MCOs were notified of their final PIA results in December 2018, which provided an opportunity for all MCOs to review and provide feedback on the results. The table below represents the funds allocation results derived from the PIA scores for each MCO.

Medallion 3.0 PIA Fund Allocation Results			
MCO	Final Award	Final Penalty	Final Award/Penalty Percentage
Plan A	\$	\$ (401,030.77)	-0.06%
Plan B	\$	\$ (125,403.82)	-0.08%
Plan C	\$ 914,400.18	\$	0.10%
Plan D	\$ 56,009.49	\$	0.13%
Plan E	\$	\$ (108,536.72)	-0.07%
Plan F	\$	\$ (335,438.37)	-0.06%
All MCO Total	\$ 970,409.68	\$ (970,409.68)	

CCC Plus Performance Incentive Program

As part of an effort to align with DMAS value based purchasing (VBP) initiatives, the CCC Plus implemented a performance incentive program that was phased in during the program's implementation. No performance incentive was provided to the CCC Plus MCOs during the initial five (5) months of implementation. The phase-in of the performance incentive began in calendar year 2018, where if the MCOs met certain data reporting of quality measures, they would earn back a 1% quality withhold. The phase in timeline for the first year of data collection is outlined below:

Phase	Dates	MCO Reporting Requirement
Phase I	1/1/2018 to 6/30/2018	Core quality measures for the LTSS population
Phase II	7/1/2018 to 12/31/2018	Core quality measures for all CCC Plus populations

MCOs that successfully report data for all of the core measures will earn back the entire 1% quality withhold, while MCOs that fail to do so will lose the entire 1% quality withhold. Beginning in calendar year 2019, DMAS will modify this performance incentive program to account for MCO performance and will align with other DMAS initiatives and strategies.

Network Accessibility and Availability

DMAS holds the MCOs in both managed care programs to time and distance standards for the network providers to ensure members have access to care within reasonable travel access for the members. DMAS monitors the MCOs in both programs by requiring regular submission of provider network files from each MCO and the files are reviewed and analyzed to monitor member accessibility and provide oversight for any potential access issues. If the MCOs fail to meet these network standards, the MCOs can face a variety of penalties, up to and potentially including monetary penalties and freezing member MCO enrollment in an affected region. DMAS also requires the MCOs to make sure that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities.

With the new CCC Plus contract, this oversight was especially critical with a new managed care program. Along with the assistance of the Office of Data Analytics, the Department closely monitored the MCOs for network adequacy with heat maps to help identify any potential gaps.

CCC Plus Networks

The CCC Plus MCOs are required to provide members with the services they need within the travel time and distance standards described in the table below. These standards apply for services that members travel to receive from network providers. These standards do not apply to providers who provide services to members at home.

CCC Plus Member Time & Distance Standards Tidewater, Central, Charlottesville/Western & Northern/Winchester Regions		
Standard	Distance	Time
Urban		
• PCPs	15 Miles	30 Minutes
• Other Providers including Specialists*	30 Miles	45 Minutes
Rural		
• PCPs	30 Miles	45 Minutes
• Other Providers including Specialists*	60 Miles	75 Minutes
Member Time & Distance Standards Roanoke/Alleghany & Southwest Regions		
Standard	Distance	Time
Urban and Rural		
• PCPs	30 Miles	45 Minutes
• Other Providers including Specialists*	60 Miles	75 Minutes

Medallion 3.0 Networks

The Medallion 3.0 MCOs are required to provide members with the services they need within the travel time and distance standards described in the table below. These standards apply for services that members travel to receive from network providers. These standards do not apply to providers who provide services to members at home. If a member lives in an urban area, they should not have to travel more than 30 miles or 45 minutes to receive services. If a member lives in a rural area, they should not have to travel more than 60 miles or 75 minutes to receive services.

Medallion 3.0: All Regions Member Time & Distance Standards		
Standard	Standard	Standard
Urban		
• PCP	15 Miles	30 Minutes
• Specialists	30 Miles	NA
• Obstetrician	NA	45 Minutes
Rural		
• PCP	30 Miles	60 Minutes
• Specialists	60 Miles	NA
• Obstetrician	NA	75 Minutes

Grievances, Appeals, and State Fair Hearings

DMAS' Appeals Division receives fair hearing requests from Medicaid enrollees who receive coverage through managed care operations and those who receive coverage through fee-for-service operations. It also receives fair hearing requests from Medicaid providers.

Member State Fair Hearings

The Appeals Division maintains the State Fair Hearing system. Medicaid enrollees and applicants can request a State Fair Hearing to appeal a denial or termination of Medicaid coverage, or a full

or partial denial of a requested Medicaid service. In SFY2018, the Appeals Division received 7,990 total requests for State Fair Hearings.

MCO-Specific Appeals

As part of the State Fair Hearing process, Medicaid recipients who receive coverage through managed care may appeal full or partial service denials rendered by participating MCOs. In order to enter into this process, the appellant must have exhausted the participating MCO's appeal process and must meet the legal criteria for a state fair hearing. Providers enrolled in Virginia Medicaid or those seeking enrollment may also request a state fair hearing of a decision rendered by an MCO if that decision is not fully favorable to the provider.

Below is a summary table of the two different categories of MCO-specific appeals:

Type of Appeal	Who can file the appeal?	Examples of Common Appeal Case Types	Levels of Appeal within DMAS	SFY2018 Total Number of Managed Care Appeals
Client	Individuals enrolled with Virginia Medicaid who have had a Medicaid service fully or partially denied by the MCO and who have exhausted the MCO's internal appeals process	Eligibility for Medicaid, service authorizations, and billing	One level of appeal	200
Provider	Providers enrolled with Virginia Medicaid or seeking enrollment who are subject to an MCO decision that is not fully favorable	Service authorizations, billing, and audits. Note: services have generally already been rendered and the provider is seeking payment	Two levels of appeal: Informal and Formal	414

Source: DMAS Appeals Division

Grievances

Medicaid enrollees who receive coverage through managed care may file a grievance with their MCO when they are dissatisfied with any aspect of their Medicaid coverage other than an adverse benefit determination (which would go through the appeal process described above). Possible subjects of grievances include (but are not limited to) quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. The MCOs are required to track trends in grievances and incorporate that information into the quality improvement process and follow all relevant state and federal regulations. While the DMAS Appeals Division does not handle grievances, records of MCO grievances and appeals must be maintained in a manner accessible to state and federal inquiry as needed.

Encounter Data Reporting

Encounter data reporting underwent major changes in state fiscal year 2018. DMAS began to use the new Encounter Data Processing System (EPS) with the implementation of CCC Plus in 2017. The Information Management (IM) division at DMAS developed this new system internally. Medallion 3.0 continued to use the traditional encounter processing system, the Virginia Medicaid Management Information System (VAMMIS), during this time for the majority of encounters, but

began transitioning pharmacy encounters to the EPS in October 2017. Medallion will fully convert to the EPS system with the implementation of Medallion 4.0 in August 2018.

The new EPS system is the first module to become operational as part of a larger DMAS system upgrade, known as the DMAS Medicaid Enterprise System. As other modules of the Medical Enterprise System become operational, validated encounters will be stored in the Enterprise Data Warehouse.

The upgrading of the DMAS encounter system is part of a larger, agency-wide commitment to improving data quality, as well as ensuring that all submitted encounters and data are timely, accurate, and complete. The integrated system redesign will allow for detailed analytics and enhanced oversight of the managed care programs.

Encounter Processing

When the MCO transmits encounter files to the new EPS system, it undergoes the rigorous process outlined below:

- When the MCO transmits encounter files to the EPS, the system checks to make sure that the data is in the exact format needed for further processing.
- The system then performs four levels of compliance checks, including a check to ensure that the data meets HIPAA mandated electronic transaction standards, and automatically accepts, rejects, or partially rejects the submitted files.
 - Rejected files are reported to the MCO to correct and re-submit.
- Accepted files then move to the next stage, where they are inspected by the DMAS Business Rules Engine (BRE), which checks each file to ensure that the encounter meets DMAS business requirements.
 - The business rules are important for validating the type of encounter submitted and the business rules the files are subjected to are specific to the Medallion or CCC Plus programs.
- After being validated using the BRE, files either receive a pass or fail status.
 - Failed encounters are reported to the MCO to be corrected by the submitter.
- Once an encounter has been completely validated, it is stored in a database for future use by other areas of DMAS.

Transitioning to the New EPS

The transition to the new EPS system required a great deal of preparation on the part of DMAS as well as the MCOs. For both CCC Plus and Medallion, an extensive Trading Partner Test plan was developed, which included regular updates, and status checks on completion. The Trading Partner Test plan involved approximately 1200 test cases per program (including all transaction types), and the cases were reviewed and approved to be deemed as pass or fail. Production capacity for the EPS was approved for the MCO based on transaction type, MCO (or subcontractor) identifier, and a “pass” status of all scenarios within that category. This rigorous testing helped the MCOs prepare for production within the EPS for each managed care program.

DMAS holds the MCOs to stringent data submission standards, which are further outlined in each program’s contract. If an MCO fails to submit timely, accurate, or complete data, including encounter data, it can be subject to compliance actions, as outlined in the next section.

Compliance

Both CCC Plus and Medallion 3.0 utilize an ongoing Compliance Monitoring Process (CMP) to detect and respond to issues of non-compliance and remediate contractual violations when necessary through progressive sanctions based on the number of points accumulated at the time of the most recent compliance violation/incident. These points accumulate over a rolling 12-month schedule. Therefore, while active points will roll over from previous contract years, any points that are more than twelve (12) months old will expire and no longer be counted. Program specific progressive sanctions are assessed on a monthly basis based on the tiered point system below:

Medallion 3.0 Compliance Points System			
Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	0-15.5	MCO Improvement Plan (MIP)	None
2	16-25.5	Corrective Action Plan (CAP)	\$5,000.00
3	26-50.5	Corrective Action Plan (CAP)	\$10,000.00
4	51-70.5	Corrective Action Plan (CAP)	\$20,000.00
5	71-100.5	Corrective Action Plan (CAP)	\$30,000.00
6	>100.5	Possible Agreement Termination	N/A

CCC Plus Compliance Points System			
Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	0-15	--	None
2	16-25	Corrective Action Plan (CAP)	\$5,000.00
3	26-50	Corrective Action Plan (CAP)	\$10,000.00
4	51-70	Corrective Action Plan (CAP)	\$20,000.00
5	71-100	Corrective Action Plan (CAP)	\$30,000.00
6	>100	Possible Agreement Termination	N/A

The MCOs can incur points for a variety of issues, including but not limited to those listed below. Each of the examples listed below increase not only in the severity of the violation, but also in the number of points assessed, from one (1) point infractions, five (5) point infractions, up to ten (10) point infractions.

- Encounter submission errors (1 point)
- Failure to use reporting format reflect in the program's Technical Manual (1 point)
- Failure to provide member materials to new members in a timely manner (5 points)
- Failure to staff 24-hour call in system with appropriately trained medical personnel (5 points)
- Discrimination among members based on health status or need for health care services (10 points)
- Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member (10 points)

Intermediate sanctions may also be assessed on the MCO per federal regulations. For more details on compliance and sanctions, please refer to the contracts for the respective managed care programs, available on DMAS' website.

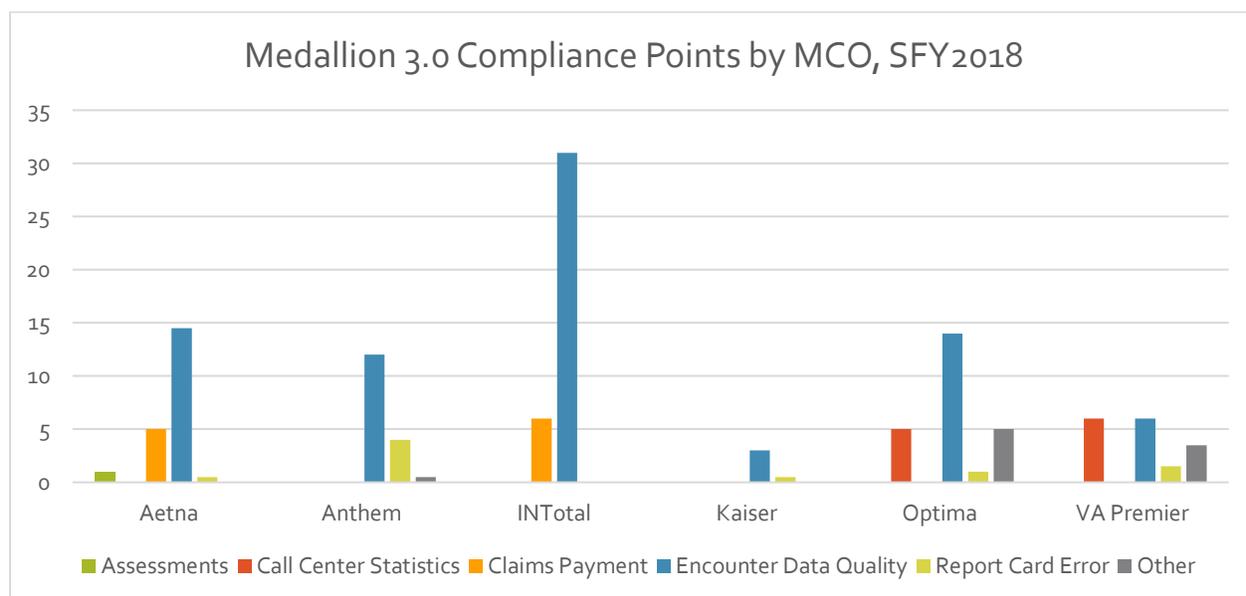
Overview of Corrective Mechanisms

The compliance point table references two different types of corrective mechanisms.

1. The MCO Improvement Plan or (MIP) is used to address minor compliance violations/failures/deficiencies, and is only used for issues that do not rise to the level of a formal corrective action plan. MIPs are not intended to be disclosed by the MCO in its business outside of the Commonwealth of Virginia. For all other purposes, a MIP functions as a Corrective Action Plan. MIPs are only utilized by the Medallion 3.0 program, and are not used by CCC Plus.
2. Corrective Action Plans (CAPs) address findings and observations that have been identified by the Department. The CAP gives the Contractor the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and state/federal regulations. Both CCC Plus and Medallion 3.0 utilize this mechanism for compliance.

Medallion 3.0 Compliance Summary

Below is a summary of compliance actions issued to the Medallion 3.0 MCOs during SFY2018.



Medallion 3.0 also issued a **total of 31 CAPs**, which have all been reviewed and resolved. It is important to note that the majority of the issues CAPs were not high-level issues, therefore, not truly requiring a CAP. Medallion 4.0 will update how CAPs are issued under the Medallion program and reserve the issuance of a CAP to high levels of non-compliance.

During SFY2018, **approximately \$450,000.00** was withheld from Medallion 3.0 capitation payments as the result of sanctions against the MCOs.

CCC Plus Compliance Summary

As CCC Plus was implemented during this state fiscal year, DMAS worked closely with the MCOs to address issues that arose during the implementation period. Oversight of MCO compliance during this time, however, was in full effect by DMAS, and some compliance actions were necessary. Below is a summary of compliance actions issued to the CCC Plus MCOs during SFY2018.

Compliance Type	Points	Health Plan	Area of Issue	Status
CAP	5	Optima	Reporting requirements, billing & claims, authorizations	Closed- all of the issues have been addressed.
CAP	5	VA Premier	Care coordination, billing & claims, authorizations	All of the issues have been addressed. The CAP is currently in a 90-day monitoring period before it will be officially closed.

Program Integrity

The trend of government payers contracting with private entities to provide care for members has created significant change in healthcare broadly, but also Program Integrity more specifically. While most Virginia Medicaid members are now covered by a Managed Care Organization (MCO), commitments to CMS regarding maintaining program integrity have remained the same.

The Program Integrity Division (PID) has created the External Provider Audit & Policy Unit (EPAP) to fulfill those commitments by providing oversight of our managed care partners through audits of MCO providers and onsite reviews of the MCOs' program integrity activities. EPAP's goal is to strengthen partnerships with MCOs, satisfy CMS requirements, and maintain DMAS' Program Integrity (PI) compliance. Such activities include providing guidance and clarification to MCO partners, collaborating around known program vulnerabilities, and auditing MCOs to ensure policy is adhered to. Specifically we have achieved the following:

- **Collaborative meetings:** Managed Care PID Collaborative meetings provide both MCOs and DMAS the opportunity to share information regarding program integrity issues. These quarterly meetings also provide a forum to identify problematic providers as well as trending fraudulent schemes. Additionally, successful approaches to mitigate and avoid abusive schemes are shared. Representatives from the Attorney General's Medicaid Fraud Control Unit (MFCU) attend these meetings and provide updates on fraud investigations.
- **Quarterly Reviews:** During quarterly reviews, MCO's must demonstrate that they are meeting DMAS program integrity requirements. PI analysts visit onsite and perform dozens of audits and tests to ensure the MCOs are meeting state and federal PI standards. A quarterly report is generated to document the review. We believe this quarterly audit process is cutting edge and a national best practice.

Key PI Accomplishments with MCO Partners

In SFY2018, the Program Integrity division focused on building stronger relationships with the managed care plans, notably with the following key accomplishments:

- Built teams of Compliance, Program Integrity and Special Investigations Unit staff at our MCO partners to tackle fraud, waste and abuse from providers and members
- Developed and maintained an open, transparent, accountable and collaborative environment to facilitate the exchange of knowledge and ideas
- Created a process by which MCO performance is reported to on a quarterly basis
- Fostered an environment in which members are encouraged to report fraud, waste and abuse
- Collaborated with MFCU staff about potential fraud, waste or abuse to maximize the success of prosecution efforts and to apply those learnings towards preventing similar FWAOs in the future

Financial Performance

In managed care, the MCOs enter a fully capitated, risk-based contract to administer each delivery system. DMAS pays the MCOs per member, per month (PMPM) capitation rates that are developed by the DMAS actuary. These rates are calculated annually, and may be modified during the annual contract renewal process. The MCOs are responsible for paying providers for covered services utilized by the member. DMAS transitioned to a new actuary, Mercer, during SFY 2018.

Minimum Medical Loss Ratio (MLR)

In order to ensure that the rates paid by the Department are being utilized to pay for covered services, the MCOs are subject to a minimum medical loss ratio (MLR) of 85%. The MLR is calculated by determining the following ratio:

- $$\frac{\text{Incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements}}{\text{adjusted premium revenue}}$$

If the MLR for a reporting year is less than 85% then the MCO must repay DMAS an amount equal to the deficiency percentage applied to the amount of adjusted premium revenue. The MCOs are required to report this annually, as well as provide DMAS with all of the necessary data to calculate and verify the MLR within eleven (11) months of the end of the reporting year (which is the contract year).

CCC Plus Financial Performance by MCO

As mandated by 42 CFR 438.66(e)(2), below is a summary of the financial performance of each MCO in CCC Plus for SFY2018. The Net: Gain or Loss row is determined by whether or not an MCO's total revenues were greater than (gain) or less than (loss) the total expenses of that MCO for the state fiscal year.

CCC Plus Financial Performance Summary, SFY2018						
MCO	Aetna	Anthem	Magellan	Optima	United	VA Premier
MLR: <85%	No	No	No	No	No	No
Net: Gain or Loss	Gain	Loss	Loss	Loss	Loss	Loss

Medallion 3.0 Financial Performance by MCO

As mandated by 42 CFR 438.66(e)(2), below is a summary of the financial performance of each MCO in Medallion 3.0 for SFY2018. The Net: Gain or Loss row is determined by whether or not an MCO's total revenues were greater than (gain) or less than (loss) the total expenses of that MCO for the state fiscal year.

Medallion 3.0 Financial Performance Summary, SFY2018						
MCO	Aetna	Anthem	INTotal	Kaiser	Optima	VA Premier
MLR: <85%	Yes	Yes	Yes	No	No	No
Net: Gain or Loss	Gain	Gain	Gain	Loss	Gain	Gain

Bureau of Insurance (BOI) Oversight

The Virginia Bureau of Insurance (BOI)'s mission is to ensure:

- Citizens of the Commonwealth are provided with access to adequate and reliable insurance protection;
- Insurance companies selling policies are financially sound to support payment of claims;
- Agents selling company policies are qualified and conduct their business according to statutory and regulatory requirements, as well as acceptable standards of conduct; and
- Insurance policies are of high quality, are understandable and are fairly priced.

The Bureau also licenses, regulates, investigates and examines insurance companies, agencies and agents on behalf of the citizens of the Commonwealth of Virginia.

Under this mission, the Medicaid managed care organizations that make up both Medallion 3.0 and CCC Plus are required to submit quarterly and annual filings to the BOI and the plans must submit those reports to DMAS at the same time. DMAS also reserves the right to require the MCOs to engage the services of an independent contractor to audit the plan's major managed care functions performed on behalf of DMAS. The audit must be conducted with generally accepted accounting principles and auditing standards.

The managed care plans also agree to work with the Provider Reimbursement division of DMAS to develop a financial report that details medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative expenses associated with the Medallion 3.0 Program. For plans with multiple Medicaid lines of business in Virginia, the quarterly report should segregate and report data for each program (CCC Plus, Medallion, etc.) and reconcile to the annual BOI reports.

Value Based Payment (VBP)

Value Based Payment (VBP) is a broad set of payment strategies intended to improve quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care.

Both CCC Plus and Medallion require the contracted MCOs to establish a VBP strategy that follows the Alternative Payment Model (APM) framework in the Final White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with special emphasis on categories 3 and 4. The White Paper can be accessed at <https://hcp-lan.org/2016/01/final-apm-framework-white-paper/>. The contracts for each program also ask each MCO to submit annual VBP plan and status reports.

Additional MLTSS Information

CCC Plus, as Virginia Medicaid's managed long-term services and supports (MLTSS) program, serves Medicaid members with complex needs. As such, additional focus areas for delivery of the CCC Plus program are emphasized for transitioning that population from fee-for-service to managed care. These include, but are not limited to, the following:

- **Continuity of care**
 - The continuity of care period was initially 90 days for the implementation of CCC Plus. This required health plans to pay for members to see existing health care providers (even those that were out of network) and to maintain existing services. Therefore, health plans were inheriting authorized services from the Fee For Service model. Health plans were required to maintain these services for 90 days or until the health risk assessment was completed.
- **Service authorizations**
 - Intensive stakeholder facilitation was utilized to create streamlined authorization processes across all six CCC Plus health plans to minimize disruption of care of the members.
- **Care coordination**
 - Members are assigned Care Coordinators to help the members and caregivers of members with complex needs navigate their care. These Care Coordinators were hired and trained by the health plans to provide this service.
- **Health Risk Assessments**
 - These assessments identify current health needs, services and gaps in care. Using the results, Care Coordinators help members address any gaps in care. This may include addressing needs through connecting to specialists, new equipment, new services or services that had lapsed.
- **Engagement and Collaboration**
 - CCC Plus engaged and collaborated closely with DMAS Program Operations and Transportation divisions to ensure the complex needs of the population served during implementation and roll out would be met.

Adherence to Medicaid Managed Care Regulations

In addition to the report requirements outlined in the introduction (42 CFR §438.66(e)), Virginia's Medicaid program also has complied with all of the applicable requirements outlined in all sections of 42 CFR §438. These pertain to the operation of Medicaid managed care programs, with

sections that are effective starting on or after July 1st, 2017. These requirements include, but are not limited to:

- Ensuring adherence to state plan requirements, including assurances that the state meets applicable statutes and regulations;
- Managed care contract review and approval by CMS prior to effective date of contract;
- Actuarially sound rates that are reviewed and approved by CMS, using rate development standards outlined in applicable sections;
- Additional monitoring and oversight requirements, including the creation of this report, state monitoring and review of the minimum MLR requirement, network adequacy standards, as well as enrollment and disenrollment standards;
- Additional program integrity safeguards, including MCO compliance review, Federal database checks, periodic audits, and increased transparency; and
- Conditions regarding Federal Financial Participation (FFP), including requirements for the state to follow for enrollee encounter data, enrollment broker services, and LTSS beneficiary support services costs.

The above list is only a brief summary of some of the additional managed care regulations found in 42 CFR §438. Virginia's Medicaid managed care programs have complied with all applicable sections of these regulations (including those not listed above) and all other federal and state regulations governing Medicaid and managed care.

Summary

The managed care programs offered by DMAS continued to be improved and refined in state fiscal year 2018. Medallion 3.0 continued the program's twenty plus year history of high quality care and focus on innovation, including preparations for the new Medallion 4.0 program, launching in August 2018. CCC Plus offered a new managed care program with an integrated delivery model and person-centered program design. DMAS is committed to promoting high quality and cost effective care for Virginians, as well as advancing value-based payment practices and delivery system reform. Managed care program oversight and accountability is a core component to realizing these initiatives, and DMAS' stewardship of these programs continues to strengthen and grow.